Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us/

INFORMATION FOR COMPLETING REGISTERED NURSE ENDORSEMENT APPLICATION

Have you ever been licensed in Wisconsin as a Registered Nurse? If yes, **do not** complete this application. For instructions on reinstating your Wisconsin license call the Board of Nursing, Renewal Office at (608) 266-0627.

REQUIREMENTS FOR ENDORSEMENT CANDIDATES

An applicant is eligible for licensure ***BY ENDORSEMENT*** if the applicant has graduated from a board-approved school of professional nursing; has passed NCLEX or a state board test pool examination for registered nurses; holds a current R.N. license in another State or U.S. Territory on which no disciplinary action has been taken; has not been terminated from employment related to nursing for reasons of negligence or incompetence; and does not have an arrest or conviction record subject to the Fair Employment Act. *(See attached Convictions and Pending Charges Form #2252.)*

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. **Application (Form #772):** Complete the enclosed application and attach the appropriate fee. Make check payable to "Department of Regulation & Licensing". Mail to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. *See page 2 of Form #772 for other required documents.*

2. **Statement of Graduation (Form #259)** *("Board-approved school" U.S. or U.S. territory)*: Complete and forward to your board-approved school of nursing. *This form must be returned directly* to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. ***Forms received from the applicant will be rejected by the board.*** *Official transcripts are not required.* If the school you graduated from is closed, contact the Department of Public Instruction in the state where you graduated to determine where the records for the closed school were transferred.

3. **Verification of Licensure (Form #741):** Complete and forward to each state in which you currently are or have ever been licensed as a Registered Nurse. (This form may be copied). *This form must be returned directly* to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. ***Verifications received from the applicant will be rejected by the Board.*** Contact each state board prior to sending this form to see if they charge a fee for this service.

4. **Temporary Permit (Form #2433) (optional):** Complete the top portion of this form and return to the board with your application and the appropriate fee.

   An applicant for R.N. licensure who holds a current license in another state, or U.S. Territory, may be eligible for a temporary permit upon submission of a completed application, supporting documents, credential fee, temporary fee, proof of graduation from a board-approved school of professional nursing, and a copy of their current license. A registered nurse licensed in another state who holds a valid Wisconsin temporary permit may use the title "Registered Nurse" or "R.N." and function without limitations. A temporary permit is good for a period of 90 days and is non-renewable.

   You may not practice as a Registered Nurse in Wisconsin unless you have either a permanent license or a temporary permit.

Wisconsin Department of Regulation & Licensing

FOREIGN GRADUATES *(including Canada)*

Statement of Foreign Nursing Education (Form #1006): Complete and forward to your board-approved school of nursing. *The school must return Form #1006 directly* to the Board of Nursing at P.O. Box 8935, Madison, WI 53708-8935. NOTE: Certified copies of original CGFNS documents of graduation are acceptable in lieu of Form #1006.

Forms received from the applicant will be rejected by the board.

COMMISSION ON GRADUATES OF FOREIGN NURSING SCHOOLS (CGFNS): Contact them at 3600 Market St., Suite 400, Philadelphia, PA 19104-2651 USA or call (215) 439-8767 to request a valid certificate *be sent directly* to the Board of Nursing, P.O. Box 8935, Madison, WI 53708-8935.

Reports or certificates received from the applicant will be rejected by the Board.

Exemption from CGFNS: If you are a graduate of an English speaking school in Canada you are exempt from CGFNS. Also, you may be exempt from the CGFNS if you have been licensed and practicing full-time for 2 consecutive years within the last 5 years in a U.S. state that does not require CGFNS. Submit a letter from your employer verifying your work history/experience.

AMERICANS WITH DISABILITIES ACT

The department complies with the Americans With Disabilities Act of 1990. The department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

REQUESTS FOR EXAMINATION MODIFICATIONS FOR PERSONS WITH DISABILITIES

Candidates must indicate at the time of application to the department that modifications are being requested. Requests must include a specific description by the candidate of requested modifications, a letter of diagnosis of specific disability from a qualified professional, and a letter from the nursing education program indicating what modifications were granted by the program. Request forms are available at (608) 266-2852 or TTY at (608) 267-2416.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

MAILING INSTRUCTIONS

Mail the application, the appropriate fee, and supporting documentation to the following address:

DEPARTMENT OF REGULATION & LICENSING
BOARD OF NURSING
PO BOX 8935
MADISON WI 53708-8935

Nursys

FORM INSTRUCTIONS

1. Only boards of nursing within the United States have access to Nursys. If you need verification of a license for a foreign country or to an agency other than a state board of nursing, please contact your state board of nursing.
2. You **MUST CONTACT** the state where you are seeking licensure to determine which state(s) they require verification from, as boards of nursing have different requirements.

   If you do not need verification of a license from one of the states listed below, **DO NOT** complete this form. Instead, follow the verification instructions of the state where you are seeking licensure. Complete this form **ONLY** if the state where you are seeking licensure requires verification from one of the states listed below.

Arizona (AZ)	Maine (ME)	Nebraska (NE)	Texas RN (TX-RN)
Arkansas (AR)	Maryland (MD)	New Mexico (NM)	Texas VN (TX-VN)
Delaware (DE)	Massachusetts (MA)	North Carolina (NC)	Utah (UT)
Florida (FL)	Minnesota (MN)	North Dakota (ND)	Vermont (VT)
Idaho (ID)	Mississippi (MS)	Ohio (OH)	Wisconsin (WI)
Iowa (IA)	Missouri (MO)	Oregon (OR)	
Indiana (IN)	Montana (MT)	South Dakota (SD)	

3. Please complete all sections of this form. Forms with missing information or incorrect payments will be returned. **SEND ONLY THIS FORM AND PAYMENT. ALL OTHER FORMS ARE UNACCEPTABLE.**
4. **PAYMENT**: To verify RN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify LPN licenses, the total fee is $30, regardless of how many states you are licensed in or how many states you are applying to. To verify both RN and LPN licenses, the total fee is $60, regardless of how many states you are licensed in or how many states you are applying to.

   All payments must be in guaranteed funds. **The only acceptable forms of payment are: certified checks, cashiers checks, or money orders** – made payable to the **National Council**. DO NOT SEND cash, personal checks, business checks, credit cards, or traveler's checks. **Fees are non-refundable.**

5. Please complete this form in blue or black ink. Print or type clearly. Illegible forms will be returned.
6. Verifications are entered into Nursys in the order in which they are received at the National Council. **The verification report will remain in Nursys for 90 days, after which it expires.** When the Board of Nursing receives your Endorsement Application, the board will access Nursys to verify any licenses held in the states listed in number 2 above. No paper reports are sent from the National Council.
7. **EXPIRED REPORTS:** If your verification has expired, you must pay an additional $30 and submit a new verification request form to the National Council.
8. Nursys information is updated monthly from the participating nursing boards listed in number 2 above. A nurse who recently received a license may have to wait until the next monthly update before the information is available in Nursys for license verification.
9. If you have questions regarding this form, please contact the Nursys License Verification Department at (312) 525-3780 or toll free (866) 819-1700.

*** **NEW** *** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to **https:\\www.nursys.com**

Nursys LICENSE VERIFICATION REQUEST FORM

*** **NEW** *** Want to process your verification faster? Try our new secure Online Verification to process your verification immediately. Go to **https:\\www.nursys.com**

Please use blue or black ink. ***See reverse side for form eligibility and instructions.*** ⇨

PERSONAL INFORMATION

Social Security Number:	Date of Birth: (mm/dd/yyyy)	
First Name:	Middle Name:	Last Name:
Maiden Name:	Date of Original License (mm/yyyy)	
Street Address:		
City:	State:	Zip/Postal Code:
Country:	Home Phone:	Work Phone:

ENDORSEMENT INFORMATION *List the license types that you need verified*

License Type (check one)		Total Verification Fee
LPN:	☐	$30.00
RN:	☐	$30.00
Both LPN & RN:	☐	$60.00

Fees are not refundable

The only acceptable forms of payment are
CERTIFIED CHECK, **CASHIER'S CHECK**,
or **MONEY ORDER**.

Made payable to: National Council
DO NOT SEND cash, personal checks, business checks, or travelers checks.

LICENSE INFORMATION *List all licenses that you have ever held*

	Jurisdiction/State	RN License Number	PN License Number
Original			
Additional			
Additional			
Additional			

States applying to: _____

_____

I, the above named individual, hereby apply for verification to the National Council of State Boards of Nursing to permit the National Council and/or its Member Boards to verify my licensure, educational, disciplinary, and related information in Nursys for the purposes of supporting my request for endorsement verification in the jurisdiction(s) listed above and any other states in which I have ever been licensed. I also confirm that the information I have submitted is true.

My application fee of $_____ in **guaranteed funds** is attached.

Mail this form to:
National Council of State Boards of Nursing, Inc.
35331 Eagle Way
Chicago, IL 60678-1353
DO NOT SEND THIS FORM TO YOUR BOARD OF NURSING

Signature_____ Date _____

Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

REGISTERED NURSE
LICENSURE BY ENDORSEMENT APPLICATION
BOARD OF NURSING

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK

☐ Your name and address are available to the public.
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth

_____ _____ _____
month day year

Daytime Telephone Number

( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

Nursing School: _____

School Address: _____
(City) (State)

Graduation Date: _____ _____ _____
month day year

Type of Degree: _____

State of Original Licensure: _____

What is your state of primary residence?

_____

If not Wisconsin, do you plan to move to Wisconsin and take up primary residence?

☐ **Yes** ☐ **No**

APPLICATION FEES

Make check payable to Department of Regulation and Licensing and attach to application.

☒ $ 66.00 Endorsement Fee

CHECK BOX FOR TEMPORARY PERMIT

☐ **$ 10.00** in addition to the above fee (*non-refundable*)

For Receipting Use Only

Wisconsin Department of Regulation & Licensing

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

1. Fee(s) attached to this completed 5 page application (Form #772).
2. Statement of Graduation from Nursing School (Form #259). (U.S. graduates only.)
3. Verification of licensure (Form #741) (include active and inactive licenses). See below.*
4. Conviction and Pending Charges (Form #2252) (if applicable).
5. Copies of malpractice suit(s) (if applicable). Submit copy of court documents of criminal complaint and judgment of conviction.
6. Statement of Foreign Nursing Education (Form #1006). (Foreign graduates only.)
7. CGFNS certificate if applicable. (Foreign graduates only.) (See Form #675.)

IS NAME ON ALL DOCUMENTS THE SAME? IF NOT, SUBMIT COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.

PRACTICE: Account for all activities and practice from date of graduation to the present time. **Must include professional and non-professional activities. ALL dates and time must be accounted for.** (Attach additional sheets if necessary.)

	EMPLOYER/ACTIVITY	CITY/STATE	DATES (from - to) mo/yr
1.			
2.			
3.			
4.			
5.			
6.			

In what state(s) do you intend to practice with your Wisconsin license? _____

I AM, OR HAVE BEEN, LICENSED IN THE FOLLOWING STATES (Include all active and inactive states):

By Written Exam: _____

By Endorsement/Reciprocity: _____

***Verification of each license you currently hold or have held is required in writing from every state board. To verify a license from a compact state use enclosed form from Nursys. For verification of all licenses in other states use From #741.**

ANSWER THE FOLLOWING QUESTIONS: (Attach additional sheets if necessary.)

		YES	NO
1.	Are you a nurse anesthetist CRNA?	❑	❑
2.	Do you anticipate taking the NCLEX in another state? If yes, in which state and date: _____	❑	❑
3.	Are you familiar with the state health laws and rules and regulations of the Wisconsin Department of Health and Family Services regarding communicable diseases?	❑	❑
4.	Have you ever surrendered, resigned, cancelled or been denied a professional license or other license in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	❑	❑
5.	Have you ever failed to pass any state board examination, province of Canada examination, or NCLEX? If yes, give details on an attached sheet.	❑	❑
6.	Has any licensing agency ever taken any disciplinary action against you, including but not limited to, any reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the licensing agency and date of action.	❑	❑
7.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	❑	❑
8.	Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges.)	❑	❑
9.	Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to Driving While Intoxicated (DWI) charges.)	❑	❑
10.	Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	❑	❑
11.	Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	❑	❑
12.	Are you registered, certified, or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	❑	❑
13.	Have you ever been registered, certified, or licensed under any other name(s)? If yes, state name(s) credentialed under.	❑	❑

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice as a registered nurse" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned nursing judgments and to learn and keep abreast of nursing developments; and
2. The ability to communicate those judgments and nursing information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform nursing tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

14.	Do you have a medical condition which in any way impairs or limits your ability to practice nursing with reasonable skill and safety? If yes, please explain.	❑	❑
15.	Does your use of chemical substance(s) in any way impair or limit your ability to practice nursing with reasonable skill and safety? If yes, please explain.	❑	❑
16.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	❑	❑
17.	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.	❑	❑
18.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.	❑	❑
19.	Are you currently engaged in the illegal use of controlled dangerous substances?	❑	❑
20.	If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	❑	❑

PLEASE READ AND SIGN BELOW

I, the above-named applicant, state that I am the person referred to in this application and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my license or other disciplinary action. I also understand that if I am issued a license, failure to comply with the laws or rules of either the Board of Nursing or the Department of Regulation and Licensing will be cause for disciplinary action.

Applicant Signature _____ Date _____

Wisconsin Department of Regulation & Licensing

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

First Name Middle Initial Last Name

Profession

Date of Birth _____ month _____ day _____ year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

[1] Section 440.03 (11m), Wis. Stats.
[2] Sections 49.22, and 440.13, Wis. Stats.
[3] Section 440.12, Wis. Stats.
[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

Wisconsin Department of Regulation & Licensing

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Website: http://www.drl.state.wi.us/

STATEMENT OF GRADUATION

("Board-approved school" U.S. or U.S. Territory)

APPLICANT: Complete the top portion of this form and forward to the school of nursing in which you received your basic nursing education. Request the school to return the completed form directly to the **Wisconsin Board of Nursing.**

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____ SOCIAL SECURITY # _____
(MONTH) (DAY) (YEAR) Voluntary, for use by school to locate your records

NURSING EDUCATION PROGRAM COMPLETED _____
(NAME OF SCHOOL OF NURSING)

LOCATION _____ DATE OF GRADUATION _____ _____ _____
(CITY) (STATE) (COUNTRY) (MONTH) (DAY) (YEAR)

I HEREBY AUTHORIZE THE _____ SCHOOL OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE - FOR SCHOOL OF NURSING

This is to certify that _____
(name)

successfully completed the nursing program at _____
(name of school of nursing)

_____ and graduated on _____ _____ _____
(location) (MONTH) (DAY) (YEAR)

The type of registered nursing completed was:
☐ BSN
☐ ADN
☐ BA
☐ DIP

The type of practical nursing completed was: ☐ LPN/TPN

Was this school of nursing state approved at the time of graduation? ☐ YES ☐ NO

SCHOOL SEAL/STAMP

Signed: _____

Title: _____

Date: _____

#259 (Rev. 02/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

1400 E. Washington Avenue
Madison, WI 53703
E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us/

STATEMENT OF FOREIGN NURSING EDUCATION

(Foreign Graduates Only, Including Canada)

APPLICANT: Complete the top portion of this form and forward to the school of nursing in which you received your basic nursing education. Request the school to return the completed form directly to the **Wisconsin Board of Nursing**.

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____
(MONTH) (DAY) (YEAR)

NURSING EDUCATION PROGRAM COMPLETED _____
(NAME OF SCHOOL OF NURSING)

LOCATION _____ DATE OF GRADUATION _____ _____ _____
(CITY) (STATE) (COUNTRY) (MONTH) (DAY) (YEAR)

I HEREBY AUTHORIZE THE _____ SCHOOL OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE - FOR SCHOOL OF NURSING

TO: DIRECTOR, SCHOOL OF NURSING: Please complete this form and return it directly to the Board of Nursing, Department of Regulation & Licensing, P.O. Box 8935, Madison, WI 53708-8935.

Date of Graduation _____ _____ _____ Type of Diploma/Degree _____
(MONTH) (DAY) (YEAR)

Was the school **accredited** at the time this applicant graduated? ☐ Yes ☐ No

If yes, what was the name of the accrediting agency? _____

What was the **primary spoken and written language of instruction** used in the school when this applicant graduated? _____

SCHOOL SEAL/STAMP

Signed: _____

Title: _____

Date: _____

#1006 (Rev. 02/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us

VERIFICATION OF LICENSURE

APPLICANT: Complete the top portion of this form and forward to the Board(s) in the state(s) in which you have ever been licensed. (This form may be copied.)

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS _____
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH _____ _____ _____ ORIGINAL LICENSE # _____
(MONTH) (DAY) (YEAR) DATE ISSUED (YEAR)

NAME OF SCHOOL OF NURSING (NO INITIALS) _____

LOCATION _____
(CITY) (STATE) (COUNTRY)

I HEREBY AUTHORIZE THE _____ BOARD OF NURSING TO FURNISH THE WISCONSIN BOARD OF NURSING THE INFORMATION REQUESTED BELOW.

DATE _____ SIGNATURE _____

DO NOT WRITE BELOW THIS LINE

STATE BOARD: Please complete this section and submit it to the Wisconsin Board of Nursing at P.O. Box 8935, Madison, WI 53708.

NAME _____
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

Original License Number _____

Date of Issuance (Month/Day/Year) _____

Check one:
☐ RN
☐ LPN

Licensed By:
☐ Examination
☐ Endorsement
☐ Waiver

Was the examination in English?
☐ Yes ☐ No

Current Licensure Status:
☐ Active
☐ Inactive
☐ Lapsed

Has this license ever been encumbered (revoked, suspended, surrendered, restricted, limited, placed on probation, etc.) in any way?
☐ Yes ☐ No If yes, attach explanation and copy of the public documents.

SEAL

Signed: _____

Title: _____

State: _____ Date: _____

#741 (Rev. 9/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

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Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
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E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us/

REQUEST FOR TEMPORARY PERMIT FOR REGISTERED NURSE OR LICENSED PRACTICAL NURSE

CHECK ONE: ☐ Registered Nurse ☐ Licensed Practical Nurse

A completed application, with proof of graduation from a board-approved school of professional nursing and the fee specified, must be received in the board office prior to granting a temporary permit. Applicants who have not taken the NCLEX or, have taken the NCLEX and are awaiting results are required to practice under the **direct supervision** of a credentialed R.N. who has a current active registered nurse license in Wisconsin. Applicants who have a current license in another state or U.S. territory are not required to practice under direct supervision.

A temporary permit is valid for 90 days or until the holder is notified he/she failed the NCLEX. **Temporary permits are non-renewable.**

NAME OF APPLICANT: (Please print) _____

Please check one:

☐ I am currently licensed as an R.N./L.P.N. in another state or U. S. Territory and have no past or pending disciplinary actions in another state. ***(May practice without direct supervision of an R.N. Statement of Supervising R.N. is not required.)*** I will be practicing in the state of Wisconsin at:

Name of Facility _____ Street Address _____

City _____, WI Zip _____ Phone Number (_____) _____

Attach a copy of your current license from another state.

☐ I plan to take the NCLEX for R.N./L.P.N. and wish to begin practicing prior to taking the examination. ***(Direct supervision by an R.N. is required)***

☐ My initial application for licensure as an R.N./L.P.N. is pending in another state or U.S. territory. I have not failed any licensing examination in another state. I wish to begin practicing pending receipt of examination results and credentialing. ***(Direct supervision by an R.N. is required.)***

STATEMENT OF SUPERVISING REGISTERED NURSE

The above-named applicant will be employed to work as an R.N./L.P.N. at the address listed below. Direct supervision by an R.N. will be provided.

The duration of this temporary permit is for a period of 90 days or until the holder is notified he/she failed the NCLEX. **Temporary permits are non-renewable.**

_____
Supervisor Signature and Title

_____
Print Name and Wisconsin RN License Number

( )
_____
Phone Number

_____
Facility Name

_____
Street Address

_____
City and State Zip Code

_____
Date

#2433 (Rev. 02/02)
Ch. 441, Stats.

Wisconsin Department of Regulation & Licensing

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935

1400 E. Washington Avenue
Madison, WI 53703

FAX #: (608) 261-7083
Phone #: **(608) 266-2112**

E-Mail: web@drl.state.wi.us
Website: http://www.drl.state.wi.us/

CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a $6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: _____

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth	Social Security Number
month _____ day _____ year _____	Information helps us identify your record, but is voluntary. It is not available to the public.

Ethnic/gender information is required to check criminal information records.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: _____

2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

   It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.

OFFENSE	DATE	CITY/STATE

Attach additional sheet(s) if necessary.

Wisconsin Department of Regulation & Licensing

		YES	NO	MO/YR COMPLETED
3.	Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program?	☐	☐	_____
	Did you successfully complete the program?	☐	☐	_____

Please attach the certificate of completion/discharge summary.

		(Check all that apply)	YES	NO	MO/YR COMPLETED
4.	Have you ever been sentenced to:	☐ Probation	☐	☐	_____
		☐ Parole	☐	☐	_____
		☐ Ordered to pay restitution	☐	☐	_____
	Did you successfully complete one of the above as ordered by the court?		☐	☐	_____

If you are <u>currently</u> on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are **<u>pending</u>**. Submit a copy of the police report/criminal complaint for each of the following pending charges.

PENDING CHARGE	DATE OF ARREST	LOCATION OF ARREST (city/state)

Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.

_____

_____

_____

_____

AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

_____ _____

Signature Date

Signed and sworn before me this _____ day of _____, 20 _____.

_____ _____

Signature of Notary Public Date

My commission (is permanent) _____ expires _____. **SEAL**

Department of Regulation & Licensing

State of Wisconsin
(608) 266-2112
TTY# (608) 267-2416] hearing or speech
TRS# 1-800-947-3529] impaired only

P.O. Box 8935, Madison, WI 53708-8935
E-Mail: dorl@drl.state.wi.us
Website: http://www.drl.state.wi.us/
FAX #: (608) 267-1803

NOTICES

TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.[a] An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

PROCEDURES ON APPLICATION DENIAL

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at *http://www.legis.state.wi.us/rsb/code/rl/rl.html* and may also be obtained from the department.

MAILING ADDRESS AND CHANGE OF ADDRESS

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at *http://www.drl.state.wi.us/* under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

AMERICANS WITH DISABILITIES ACT

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

Communications and examinations: Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

Complaints: Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 10/00) ss. 15.04 (1) (m), 19.35, Stats.

[a] Section RL 4.06 of the Wisconsin Administrative Code